OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
NHSC/STATE LOAN REPAYMENT PROGRAM

PRIMARY CARE HEALTH PROFESSIONAL APPLICATION

GOOD FOR USE IN 2004/2005 GRANT PERIOD ONLY

SECTION I - PERSONAL DATA

Please type or print with ink

Applicant Name: _____

Home Address: _____

City: _____ State: _____ Zip + 4: _____

Day Phone: (_____) _____ Evening Phone: (_____) _____

Social Security #: _____ Birth Date: _____

1. Are you a United States citizen? ____Yes ____No
2. Do you have a current and unrestricted California license to practice your profession? ____Yes ____No
3. Are you free of unserved obligations for service? ____Yes ____No (If no, attach explanation)
   (i.e., Federal, State, local government, or other entity)
4. Are you free of judgments arising from Federal debt? ____Yes ____No (If no, attach explanation)
5. Are you delinquent with any court ordered child support? ____Yes ____No (If yes, attach explanation)
6. Have you had any cultural competency training? ____Yes ____No (If yes, attach explanation)
   (Communities studied i.e., Hmong, Russian, et. al.)
7. Are you fluent in any other language(s) besides English? ____Yes ____No (If yes, attach explanation)
   [Include basic medical language(s) training.]
8. Have you had training or work experience in a medical, dental, or mental health underserved area? ____Yes ____No (If yes, attach explanation)

SECTION II - GENDER/RACE/ETHNICITY DATA

Please check the appropriate items

___ Male ___ Female

___ American Indian or Alaska Native

___ Asian

___ Black or African American

___ Hispanic or Latino

___ Native Hawaiian or Other Pacific Islander

___ White

___ Other

SECTION III - HEALTH PROFESSION

Please check the appropriate item(s)

___ M.D. ___ D.O.

___ Family Physician
___ General Internist
___ General Pediatrician
___ Obstetrician-Gynecologist
___ General Psychiatrist

___ Physician Assistant
___ Nurse Practitioner
___ Certified Nurse-Midwife
___ Dentist (D.D.S.)
___ Dentist (D.M.D.)

___ Clinical/Counseling Psychologist
___ Licensed Clinical Social Worker
___ Mental Health Counselor
___ Licensed Professional Counselor
___ Marriage and Family Therapist

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SECTION IV - HEALTH PROFESSIONAL EDUCATION

School: _____ Date of Graduation: _____

City: _____ State: _____ Zip + 4: _____

Postgraduate Training: _____ Year completed: _____

Board Eligible: _____ Board Certified: _____ CA License Number: _____

Certificate Number: _____

SECTION V - PRACTICE SITE

1. Applicant agrees to provide full-time 40 hrs./wk. (including a minimum of 32 hrs. direct patient care) at:

- Practice Site Name: _____ **Percentage of time** _____

  Address: _____

  City: _____ County: _____ Zip + 4: _____

- Practice Site Name: _____ **Percentage of time** _____

  Address: _____

  City: _____ County: _____ Zip + 4: _____

2. Practice Site Contact Person: _____

   Title: _____ Telephone No.: _____

3. Applicant agrees to provide full-time direct patient care, at the site(s) named above, for:

   _____ 2 Years _____ 3 Years _____ 4 Years

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SECTION VI - EDUCATIONAL DEBT

All applicants must submit a current loan statement for each loan listed below. Each statement must contain the Applicant's name, account number, the principle and interest amounts and/or the payoff balance.

1. Loan Company Name: _____
("Payee")

Loan Company Address: _____
(Payee Address)

City: _____ State: _____ Zip + 4: _____

Account Number: _____ Loan Balance: $ _____

2. Loan Company Name: _____
("Payee")

Loan Company Address: _____
(Payee Address)

City: _____ State: _____ Zip + 4: _____

Account Number: _____ Loan Balance: $ _____

3. Loan Company Name: _____
("Payee")

Loan Company Address: _____
(Payee Address)

City: _____ State: _____ Zip + 4: _____

Account Number: _____ Loan Balance: $ _____

4. Loan Company Name: _____
("Payee")

Loan Company Address: _____
(Payee Address)

City: _____ State: _____ Zip + 4: _____

Account Number: _____ Loan Balance: $ _____

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SECTION VI - EDUCATIONAL DEBT (Continued)

5. Loan Company Name: _____
("Payee")

Loan Company Address: _____
(Payee Address)

City: _____ State: _____ Zip + 4: _____

Account Number: _____ Loan Balance: $ _____

6. Loan Company Name: _____
("Payee")

Loan Company Address: _____
(Payee Address)

City: _____ State: _____ Zip + 4: _____

Account Number: _____ Loan Balance: $ _____

SECTION VII - CERTIFICATION

I certify that all statements made in this application are complete and accurate to the best of my knowledge. I understand that falsification will disqualify my application. I authorize representatives of the Office of Statewide Health Planning and Development to contact institutions holding any of the listed educational loans, educational institutions I attended, and employers to verify the accuracy of the information contained in this application.

Signature: _____ Date: _____

Please submit the application, and relevant loan statements, via the practice site contact person.

DO NOT WRITE BELOW THIS LINE

Application Received: _____ HPSA ID#_____ Cleared by NHSC: _____

Comments: _____